

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G408	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/14/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  AWS	STREET ADDRESS, CITY, STATE, ZIP CODE 8419 COVINGTON RD FORT WAYNE, IN 46804
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 05/14/14</p> <p>Facility Number: 000922 Provider Number: 15G408 AIM Number: 100244500</p> <p>Surveyor: Brett Overmyer, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, AWS was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>The one story facility was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K010000		
---------	---	---------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G408		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  05/14/2014	
NAME OF PROVIDER OR SUPPLIER  AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 8419 COVINGTON RD FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K01S014	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.48.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/19/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Interior wall and ceiling finish is Class A or Class B in accordance with section 10.2, 33.2.3.2. There are no requirements for interior floor finish.</p> <p>Exception: Class C interior wall and ceiling finish is permitted in prompt evacuation capability facilities.</p> <p>Based on observation and interview, the facility failed to ensure the laundry room wall was completely finished with</p>	K01S014	The contractor was notified of the need for the repair to the wall. The opening exposing the wood studs behind the washer and	06/13/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G408	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  05/14/2014
NAME OF PROVIDER OR SUPPLIER  AWS			STREET ADDRESS, CITY, STATE, ZIP CODE 8419 COVINGTON RD FORT WAYNE, IN 46804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>drywall to provide a Class A or Class B interior finish. This deficient practice could affect all residents and staff.</p> <p>Findings include:</p> <p>Based on observation and interview with the Residential Manager and Residential Director during a tour of the facility on 05/14/14 between 10:10 am and 10:25 am, an opening exposing the wood studs behind the washer and dryer extended up from the floor two feet and across from one wall to the other, approximately six feet.</p>		<p>dryer will becompletely finished with drywall prior to 6-13-14. The residentialmanager will notify the residential director at the time of therepair. The residential director will complete an inspection of therepaired wall and ensure that it meets the requirements for lifesafety. The residential manager will document the repaired wall onthe AWS-Benchmark Residential Maintenance Report for the month ofJune. Ongoing maintenance reports will be completed monthly andturned into the residential director for review and insure timelycompletion of maintenance repairs.</p>		